Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0101	A. BUILDING _____ B. WING _____	C 03/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARCLIFF HEALTH CARE CENTER	100 ELMHURST DR OAK RIDGE, TN 37830

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 669	1200-8-6-.06(4)(c)4. Basic Services (4) Nursing Services. (c) The Director of Nursing shall have the following responsibilities: 4. Notify the resident ' s physician when medically indicated. This Rule is not met as evidenced by: Pending Type C Penalty # 4 Tennessee Code Annotated 68-11-804(c)4: Nursing homes shall notify the patient's physician of the condition of a patient when it is medically indicated. Based on medical record review, review of facility policy, review of the facility's investigative documentation, observation, and interview, the facility failed to timely notify the physician regarding an allegation of rape for one resident (#5) of five sampled residents. The findings included: Resident #5 was admitted to the facility on October 1, 2009, with diagnoses including Mental Disorder and Depressive Disorder. Medical record review of a history and physical dated September 29, 2009, revealed, "...positive paranoia with accusatory delusions..." Medical record review of an interdisciplinary assessment dated January 3, 2010, revealed the resident was impaired with decision-making skills, had repetitive health related complaints, and needed extensive assistance with transfers, walking, and hygiene/grooming. Medical record review of a	N 669	N669 It is the policy that the facility immediately inform the resident; consult with the resident's physician; and, if known, notify the resident's legal representative or an interested family member when there is an accident which results in injury and has the potential for requiring physician intervention. 1. The resident's treating physician and Medical Director were notified of the resident's allegation of abuse by the Social Services Director on 2/16/2010, immediately after the allegation was brought to a Supervisor's attention. 2. The resident's son was notified by the Social Services Director on 2/16/2010, immediately after the allegation was brought to the Social Services Director's attention.	2/16/10 2/16/10

Division of Health Care Facilities

[signature], NHA — TITLE: Administrator — (X6) DATE: 3/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

MAR 30 2010

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N 669	Continued From page 1 care plan effective through April 11, 2010, revealed, "...Monitor and document behavior and report any abnormal observations to physician..." Review of the facility's abuse policy number: SS.III-001 revealed, "...Employee shall notify the Supervisor immediately when abuse is suspected...Family and Physician are to be notified that an investigation is taking place..." Review of the facility's Notification of Changes policy number: N-N-005, revealed, "...Licensed Nurse will notify the Attending Physician when a change in health status occurs..." Review of a facility report dated February 17, 2010, revealed, "...Date of occurrence: 2/16/2010...Administration...notified in morning meeting...(resident) said during a treatment session that (resident) had been 'raped about 2 weeks ago'. " Medical record review revealed no documentation dated February 15, 2010, regarding the allegation of rape. Interview with a certified occupational therapy assistant (COTA) on March 12, 2010, at 1:00 p.m., in the conference room, revealed the resident reported an allegation of rape to the COTA on February 15, 2010, at the end of a therapy treatment. Continued interview revealed the COTA reported the allegation to a social service assistant on February 15, 2010. Review of a handwritten statement signed by a social service assistant, revealed, "On Monday (2/15/10), (COTA)...proceeded to tell me that (resident) had told (COTA) today that a few weeks ago a man tried to rape (resident)..."	N 669	3. All licensed and non-licensed staff were inserviced by the Staff Development Coordinator by 4/2/2010 on the importance of reporting abuse or neglect allegations immediately so the investigation process, physician notification and family notification can begin on the day of the allegation. 4. To insure that untimely reporting does not reoccur, the Social Service Director conducted a facility-wide survey by 2/23/2010 of all staff on policy N-N-005; Notification of Changes and the importance of timely notification of the physician, legal representative or family member on changes in resident condition, treatment or potential for requiring physician intervention. As part of the survey, the employees were required to sign a	4/2/10 2/23/10

EAR CQP, NHA

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3/26/10

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N 669	Continued From page 2 Observation and interview with the alert, oriented resident on March 12, 2010, at 12:00 p.m., revealed the resident in no apparent distress, and the resident stated, "One time a man was in my room trying to molest me...He told me I better not tell anybody...Do I have to tell you about that? It makes me nervous to talk about it." Interview with the director of nursing on March 12, 2010, at 2:40 p.m., revealed the allegation of rape was not reported to nursing or the physician until February 16, 2010. Telephone interview with the resident's attending physician on March 15, 2010, at 12:00 p.m., confirmed the physician was not notified regarding the allegation of rape until February 16, 2010. C/O: #25129	N 669	statement that they would report allegations immediately and the importance of the need to report timely and in accordance with regulation and policy was reiterated. 5. To assess other residents having the potential to be affected by untimely notification of changes, a Social Services Assistant interviewed all interviewable residents on 2/17/2010. As part of the survey, the residents were questioned regarding how to report concern and educated on the importance and mechanism of reporting any concerns immediately. 6. To measure the effectiveness of the plan of correction, beginning 3/15/2010, the Risk Manager shall monitor timely physician and family notification for all incidents and accidents consistent with F157 and	2/17/10 3/15/10

EA Caudle, NHA 3/26/10

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			policy N-N-005; Notification of Changes. 7. In the event that the plan of correction does not achieve the facility goal of timely notification, the Risk Manager shall report any instances of noncompliance to the CQI / QA & A Committee, that will discuss the plan of correction interventions and make recommendation for additional interventions as necessary. The QA & A Committee consists of the Director of Nursing, a physician and at least, but not limited to, three other team members to include the Administrator, a Social Worker, and an LPN or RN.	

MAR 30 2010